MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.

Meghan Siguentes Vanderstelt

Director, Bureau of Policy and Strategic Engagement
Health Services Administration

Project Number:	2632-Clinic	**Comments Due:**	November 2, 2026	**Proposed Effective Date:**	April 1, 2027

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Policy Subject: Medicaid Health Plan Clinic Prospective Payment System/All-Inclusive Rate Reimbursement Transition

Affected Programs: Medicaid, Healthy Michigan Plan

Distribution: Federally Qualified Health Centers (FQHCs), Tribal Health Centers, Tribal FQHCs, Rural Health Clinics, Medicaid Health Plans

Policy Summary: The purpose of this bulletin is to notify providers of a Medicaid Health Plan (MHP) reimbursement transition for medical and behavioral health services provided by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal Health Centers (THCs) and to provide guidance on billing procedures and other requirements related to this transition. MHPs will reimburse eligible services at the Prospective Payment System (PPS) rate or the Indian Health Services (IHS) outpatient All-Inclusive Rate (AIR) for services performed on or after April 1, 2027.

Purpose: To provide guidance on the necessary changes to reimbursement, billing procedures, and other requirements related to transition of MHP reimbursement to the PPS/AIR methodologies.

Proposed Policy Draft

Michigan Department of Health and Human Services
Health Services

Distribution: Federally Qualified Health Centers (FQHCs), Tribal Health Centers, Tribal FQHCs, Rural Health Clinics, Medicaid Health Plans

Issued: March 1, 2027 (Proposed)

Subject: Medicaid Health Plan Clinic Prospective Payment System/All-Inclusive Rate Reimbursement Transition

Effective: April 1, 2027 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan

The purpose of this bulletin is to notify providers of a Medicaid Health Plan (MHP) reimbursement transition for medical and behavioral health services provided by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal Health Centers (THCs) (e.g., Indian Health Services, Tribal FQHCs, and Urban Indian Organizations). Eligible services are reimbursed by the MHPs at a rate no less than the Prospective Payment System (PPS) rate or the Indian Health Services (IHS) outpatient all-inclusive rate (AIR). The bulletin provides guidance on the necessary changes to reimbursement, billing procedures, and other requirements related to transition to the PPS and AIR methodologies. Information in this bulletin is effective for dates of service on and after April 1, 2027.

Throughout this policy, any reference to health centers or clinics pertains to all the above-mentioned provider types unless otherwise stated.

Historically, FQHC, RHC, and THC services have been reimbursed by MHPs at the applicable fair market rate negotiated between the health center and the MHP or the Michigan Department of Health and Human Services (MDHHS) Managed Care Organization (MCO) suggested rate. Effective for dates of service on and after April 1, 2027, Medicaid-covered medical services, including vision services and antepartum care visits, and behavioral health services provided by a health center are reimbursed by the MHPs at the clinic's current PPS rate or AIR. The AIR applies to clinic encounters for both native and non-native Medicaid beneficiaries and is not contingent upon the THCs network participation with the MHP. These medical and behavioral health services are ineligible for additional differential "wrap around" supplemental and quarterly advance payments from MDHHS.

Requirements of the PPS and AIR reimbursement methodologies remain applicable per the MDHHS Medicaid Provider Manual.

Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP) beneficiaries are excluded from the PPS/AIR reimbursement transition. MHPs continue to reimburse health center services performed for HIDE-SNP beneficiaries according to existing payment processes.

Excluded Services

The following services continue to be paid by the applicable MHP, PIHP, or Dental Health Plan (DHP) at the fair market rate negotiated between the health center and the health plan/program or the MCO suggested rate:

- Dental services
- THC or Tribal FQHC pharmacy prescription encounters
- Prepaid Inpatient Health Plan (PIHP) contracted specialty behavioral health services
- Maternal Infant Health Program (MIHP) services.

These excluded services remain eligible for PPS/AIR reimbursement through existing payment processes. Consistent with current policy, providers may choose to opt out of MDHHS quarterly advances for the excluded services by notifying the MDHHS Hospital and Clinic Reimbursement Division (HCRD).

If a covered procedure code is excluded from the health center's PPS/AIR methodology, the service is reimbursed by the MHP at the established Medicaid fee screen rate. These payments are listed on the associated procedure code's line and are not eligible for PPS/AIR. Services subject to the fee screen reimbursement are indicated as "excluded" on the Medicaid FQHC, RHC, and THC fee schedules published at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Clinic Institutional Billing.

Reconciliation

An annual reconciliation cost report is required and should be submitted to MDHHS by the health center on or before the last day of the fifth month following the close of its cost reporting period fiscal year end. The report allows MDHHS to ensure the health center is receiving the full PPS/AIR reimbursement rate from the MHP for all qualifying visits per the PPS or AIR reimbursement methodology outlined within the Federally Qualified Health Centers, Rural Health Clinics, and Tribal Health Centers chapters of the MDHHS Medicaid Provider Manual.

Billing and Reimbursement

Billing procedures remain unchanged. As a reminder, Health center services must be billed according to instructions published in the Billing & Reimbursement for Institutional Providers and Federally Qualified Health Centers, Rural Health Clinics, and Tribal Health Centers chapters of the MDHHS Medicaid Provider Manual.

MHPs reimburse PPS/AIR for all covered medical or behavioral health services furnished to a beneficiary on the same day as an allowable encounter. An allowable encounter is a medically necessary face-to-face health center visit or qualifying telemedicine service provided by a healthcare provider who exercises independent judgment in the provision of health care services. (Refer to the Federally Qualified Health Centers, Rural Health Clinics, and Tribal Health Centers chapters of the MDHHS Medicaid Provider Manual for additional information on a qualifying encounter.) Services qualifying for PPS/AIR reimbursement are indicated on the clinic fee schedules published at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Clinic Institutional Billing.

Consistent with current practice, all related medical or behavioral health services performed during a single day must be billed on the same institutional claim. The health center may be credited with one encounter for each different type of visit (medical, behavioral health, dental) provided to a beneficiary during a single day, regardless of the number of services provided at the visit. Additional diagnosis and treatment services occurring on the same date of service may be classified as two medical encounters.

All qualifying visit services must be reported on the claim in combination with an encounter payment code (e.g. G0466-G0470, T1015) on a separate line in order to receive the PPS/AIR encounter reimbursement rate from the MHP. Qualifying antepartum maternity global care services (59425-59426) are also eligible to receive the PPS/AIR encounter reimbursement rate from the MHP, but do not require an encounter payment code.

Rate Changes

The Medicaid PPS visit rate is adjusted annually using the Medicare Economic Index (MEI) and the AIR is adjusted using the Federal IHS rate. An FQHC's or RHC's PPS rate may also be modified to reflect changes in the scope of services provided to Medicaid beneficiaries by the clinic. MHP PPS and AIR reimbursement rates are updated according to any MDHHS approved change and claims are adjusted as necessary.

Coordination of Benefits

Qualified medical and behavioral health services provided for MHP beneficiaries who are enrolled in Medicare or another primary health insurance are eligible for PPS or AIR reimbursement. The MHP is responsible for payment of covered services up to the health center's PPS rate/AIR minus any payment amounts made by other payors. If the payment received from Medicare or other insurance for a specific service exceeds the Medicaid PPS/AIR amount, the health center must still bill the procedure code to receive credit for encounter and reconciliation purposes.